

## MEDICAL RECORDS RELEASE

I AUTHORIZE:	RELEASE TO:
Sender	Destination
Address	Address
City/State	City/State
FOR THE PURPOSE OF:	
Type of Information to be released (which may in	nclude information obtained after this date). (Circle all that apply)
Medical Records, Progress Notes Medical Records	dications Medical History & Physical
Laboratory and x-ray Reports Other	er, Please Specify
FOR:	
Patient's Name (at time of treatment)	Patient's Date of Birth
Street Address	Patient's Social Security Number
City State Zip Code	Daytime Telephone Number VDPH#
As the person signing this consent, I understand that I am giving my permission to the Virginia Beach Department of Public Health for disclosure of confidential health care records as specified above. I also understand that I have the right to revoke this consent, but that my revocation is not effective until delivered in writing to the person who is in possession of my records. A copy of this consent and a notation concerning the persons or agencies to whom disclosure was made shall be included with my original records. The person who receives the records to which this consent pertains may not re-disclose them to anyone else without my separate written consent unless such recipient is a provider who makes a disclosure permitted by law.  Today's Date	
· · ·	of Parent or Legal Guardian when Required

The Department of Health as a matter of policy does not provide HIV test results or substance abuse information in response to a request for release for medical records or a subpoena duces tecum unless their release is specifically authorized in the release signed by the patient or the subpoena is accompanied by a court order issued in accordance with 42 C.F.R. Part 2, Subpart E.